

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03488					03482				
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Elkton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS R.D. # 5 Box 112 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Robert First E. Middle Barrow Last			4. DATE OF DEATH March Month 21 Day 1967 Year						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1919		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR: Months 07 Days 1 IF UNDER 24 HRS.: Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman			10b. KIND OF BUSINESS OR INDUSTRY Budd Co.			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert R. Barrow					14. MOTHER'S MAIDEN NAME Eva Rink				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW2		17. INFORMANT Mrs. Dorothy M. Barrow, Elkton, Md. Address R.D. 5				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Curriculum of fever, metastatic DUE TO (c) Curriculum of Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 3			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-30 , 19 67 , to March 21, 1967 , that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 11:55 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Rolando A. Najera					22b. DATE SIGNED 3/24/67				
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera					22d. ADDRESS 105 E. Main St. Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		23d. LOCATION (City, town or county) (State) Rising Sun, Md.		
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.					25a. REC'D BY REGISTRAR MAR 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

03182

Geoff

Maryland

Elkton

7.5.5 Box 112

March 21, 1957

Barrow

Sept. 1, 1959

Maryland

U.S.A.

Bus Ride

Mrs. Dorothy M. Barrow, Elkton, Md.

Geoff

Elkton

Union Hospital

Robert

White

Male

Foreman

Dad No.

Robert H. Barrow

WAS

Yes

Volando A. Hejers

105 E. Main St., Elkton, Md.

Brookview Cemetery

Elkton, Md.

Elkton Home for the Elderly, Elkton, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03489						03483					
1. PLACE OF DEATH e. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun				c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville				d. STREET ADDRESS Jarrettsville Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Beading						4. DATE OF DEATH Month March Day 14, Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/1884		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Saw mill		11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Beading						14. MOTHER'S MAIDEN NAME Elizabeth Harman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 215-12-3370A					
17. INFORMANT Mrs. Lillie M. Johnson						Address Jarrettsville Road Forest Hill, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac Failure 4211 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } Aortic Stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 21050 INTERVAL BETWEEN ONSET AND DEATH ?											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from March 14, 1967, to March 17, 1967, that (I) (we) last saw the deceased alive on March 14, 1967, and that death occurred at 4 P.M., from the causes and on the date stated above.											
22a. SIGNATURE Ernest W. Seiter, M.D.						22b. DATE SIGNED March 14, 1967					
22c. PHYSICIAN'S NAME (Type) Ernest W. Seiter, M.D.						22d. ADDRESS 28 W. Cherry St. Rising Sun, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/18/1967		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius				23d. LOCATION (City, town or county) (State) Hickory, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz						25a. RECEIVED BY REGISTRAR MAR 17 1967					
ADDRESS Jarrettsville, Md.						25b. REGISTRAR'S SIGNATURE Charles Judge					

0323

03490

CERTIFICATE OF DEATH

03484

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 Yr 8 Mo 8d			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.				d. STREET ADDRESS 3616 Forrest Hill Road			
3. NAME OF DECEASED (Type or print) ERNEST G BOUIS				4. DATE OF DEATH Month March Day 18 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-16-95	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Clarence G. Bouis (D)			
14. MOTHER'S MAIDEN NAME Hattie Moore (D)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. 213-05-78-86				17. INFORMANT VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Acute, Severe DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Broncho- Pneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from July 10, 1965 , to March 18, 1967 , that (b) (we) lost now the deceased since on xxxxxxxxxx and that death occurred at 9:00 AM , from causes and on the date stated above.							
22a. SIGNATURE H. E. Connor				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-18-67	
22c. PHYSICIAN'S NAME (Type) H. E. CONNOR, M.D.				22d. ADDRESS VAH., Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/21/67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikeville Balto. Md.	
24. FUNERAL DIRECTOR LORING BYERS				25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03491

CERTIFICATE OF DEATH

03485

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 4 mos 19 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 11602 Bucknell Drive c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 11602 Bucknell Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HENRY M. CARPENTER		4. DATE OF DEATH Month Day Year March 1 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-92
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Concord, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin (D)		14. MOTHER'S MAIDEN NAME Mary (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 578-34-7438	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease with myocardial fibrosis DUE TO (c) sudden INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from Oct. 13 , 19 66 , to March 1 , 19 67 , that the deceased was the deceased alive on xxxxxxxxxxxx 19xx , and that death occurred at 2:50 am , from causes and on the date stated above.			
22a. SIGNATURE Agustin R. Garcia		22b. DATE SIGNED 3-1-67	
22c. PHYSICIAN'S NAME (Type) J. R. GARCIA, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-3-67	
23c. NAME OF CEMETERY OR CREMATORY ALEX. NAT. CEMETERY		23d. LOCATION (City or Town) (County) (State) ALEXANDRIA - VA.	
24. FUNERAL DIRECTOR Lee Funeral Home, 4th & Mass. Ave., NE., Wash.		25a. REC'D BY REGISTRAR DC 25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAR 6 1967			

03182

03182

STATEMENT OF DEBIT

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03492

CERTIFICATE OF DEATH

03486

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 12-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 811 N. Adams Street	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT J. CHRISTY		4. DATE OF DEATH Month Day Year March 16 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-95
9. AGE (In years lost birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver, ret.		10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber Company</i>	
11. BIRTHPLACE (County & State, or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Christy (D)		14. MOTHER'S MAIDEN NAME Sarah Christy (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 057-14-8963	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Feb. 23 , 19 67 , to March 16 , 19 67 , and that death occurred at 6:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>J. R. Garcia M.D.</i>		22b. DATE SIGNED 3-17-67	
22c. PHYSICIAN'S NAME (Type) J. R. GARCIA, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-22-67	23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery	23d. LOCATION (City or Town) (County) (State) Cabersdeen Harford Md
24. FUNERAL DIRECTOR <i>Bullock</i> Bullock Funeral Home, Havre de Grace, Md.		25a. REC'D BY REGISTRAR MAR 20 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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03388

03388

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, including various administrative markings and stamps.]

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03493

CERTIFICATE OF DEATH

03487

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 17 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 373 W. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First David Middle L. Last Cleaves		4. DATE OF DEATH Month March Day 9 Year 19 67		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1900		9. AGE (In years last birthday) 67 yrs.		10. FUND 1 YEAR Months 67		11. FUND 24 HRS. Days 67		12. HOURS 67		13. MIN. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY DuPont Co.				11. BIRTHPLACE (County & State, or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John H. Cleaves				14. MOTHER'S MAIDEN NAME Margaret A. Ford				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 221-07-6415				17. INFORMANT 373 W. Main St. Mrs. David L. Cleaves, Elkton, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Diabetes Mellitus																INTERVAL BETWEEN ONSET AND DEATH 12 hours years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 3/9/67 , 19 67 , to 3/9/67 , 19 67 , that (I) (we) last saw the deceased alive on 3-9-67 , 19 67 , and that death occurred at 8 P.M. from the causes and on the date stated above.																							
22a. SIGNATURE Tillman D. Johnson M.D.																22b. DATE SIGNED 3-9-67							
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.																22d. ADDRESS 123 S. S. Highway, Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/12/67				23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery				23d. LOCATION (City, town or county) (State) Elkton, Md.											
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.																25a. REC'D BY REGISTRAR MAR 14 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

03487

03487

Cecil

Wilmington

Cecil

Wilmington

11 yrs.

Wilmington

375 W. Main St.

Union Hospital

March 2, 1900

Cleaves

I.

David

X

Feb. 12, 1900

White

Male

U.S.A.

Delaware

Dupont Co.

Margaret A. Ford

John H. Cleaves

375 W. Main St.

221-07-6418 Mrs. David L. Cleaves, Wilmington, Del.

W. S.

Yes

Wilmington, Del.

Wilmington Cemetery

2/12/07

Funeral

Wilmington, Del.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

<div>Item 18 Fillm 387 4-19-67 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>03494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03488</div>											
1. PLACE OF DEATH a. COUNTY CECIL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville 07-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trailer Camp - Susquehanna Avenue						d. STREET ADDRESS Wm. Zurlin's Trailer Camp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS J. COCKRELL, Jr						4. DATE OF DEATH Month Day Year 3 6 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-6-1922		9. AGE (In years lost birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alexander, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Cockrell, Sr.						14. MOTHER'S MAIDEN NAME Gladys Ewald					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W W II				16. SOCIAL SECURITY NO. 225-34-0649		17. INFORMANT Address Cunningham Funeral Home, Alexander, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) No cause of death determined 7953 DUE TO due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Advanced decomposition (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz				EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				22. DATE SIGNED 3-7-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3-13-1967		23c. NAME OF CEMETERY OR CREMATORY Alexander National Cem.		23d. LOCATION (City or Town) (County) (State) Alexander, Virginia			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR DATE MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

03188

03188

10-1-50

10-1-50

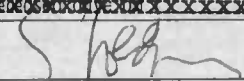
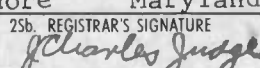
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03495

CERTIFICATE OF DEATH

03489

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY in 1b 21 days 5 yrs. 8 mos.	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 5115 Balto. Nat'l. Pike			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN		Middle P.		Last DEL GUIDICE Jr.		4. DATE OF DEATH Month March		Day 28
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-21		9. AGE (In years last birthday) 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Electric		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John DelGuidice				14. MOTHER'S MAIDEN NAME Nellie Day Lang				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT VA Hospital Records, Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH -----
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from April 6, 1960 to March 28, 1967 , that (X) (this hospital) attended the deceased from April 6, 1960 to March 28, 1967 , and that death occurred at 5:00 am from causes and on the date stated above.								
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-28-67				
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VAH, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-30-67		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Funeral Home, Towson, Md.				25a. REC'D BY REGISTRAR MAR 31 1967		25b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02550

1234

123

30101 0728

204-15

Journal of Management Education 27(6)

03496

CERTIFICATE OF DEATH

03490

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1604 Park Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MYRON M EMERSON		4. DATE OF DEATH Month Day Year March 17 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-99
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 Year Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator		10b. KIND OF BUSINESS OR INDUSTRY Emersonian Apts	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Emerson (D)		14. MOTHER'S MAIDEN NAME Eva M. Saunders (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 569-01-2883	
17. INFORMANT VA Hospitals Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Kimmelstiel - Wilson Disease DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema - - Hypertensive Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 20 , 19 67 , to March 17, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 17, 1967 , and that death occurred at 8:50 AM , from causes on the date stated above.			
22a. SIGNATURE <i>Frederic J. Gillis</i>		22b. DATE SIGNED 3-17-67	
22c. PHYSICIAN'S NAME (Type) A. G. Gillis, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/21/67	
23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR 3331 Brehms Lane Schimunek Funeral Home		25a. REC'D BY REGISTRAR MAR 22 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4280

00150

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03497

CERTIFICATE OF DEATH

03491

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH	
c. LENGTH OF STAY IN 1b 173 days		d. STREET ADDRESS 704 Villa Ridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last HAYES		4. DATE OF DEATH Month March Day 18 , Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-88
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min. 10	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. ARMY		11b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
11. BIRTHPLACE (County & State, or foreign country) Ironton, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Hayes (D)		14. MOTHER'S MAIDEN NAME Susanna T. Davis (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 6-12-12 to 7-15-50		16. SOCIAL SECURITY NO. 225-46-4963	
17. INFORMANT Address VA Hospital Records Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis, Generalized - Severe DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5-10 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from 9-26-66 , 19 66 , to 3-18-67 , 19 67 , that the deceased died on 18 , 19 67 , at 1:00 P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>S. Goldgraben</i>		22b. DATE SIGNED 19 Mar. 67	
22c. PHYSICIAN'S NAME (Type) S GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 3/21/67	23c. NAME OF CEMETERY OR CREMATORY West Point Military Cem.	23d. LOCATION (City or town) (County) (State) West Point, N. York.
24. FUNERAL DIRECTOR <i>Tarring Funeral Home, Aberdeen, Maryland</i>		25a. REC'D BY REGISTRAR MAR 21 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03101

CONTINUED OF DEATH

03101

Received 3/21/07 West Point Military Cemetery, West Point, N.Y.

FOR STATE
HEALTH DEPT.

03498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03492

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs		c. LENGTH OF STAY IN 1b Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elk Paper Company		d. STREET ADDRESS RD #3, Box 420	
3. NAME OF DECEASED (Type or print) First Middle Last RAY H. JUSTICE		4. DATE OF DEATH Month Day Year March 21 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1934 33 yrs.
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Elk Paper Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Justice		14. MOTHER'S MAIDEN NAME Georgie Stacy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 226-38-2428	
17. INFORMANT Mrs. Gladys Justice, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into pulp beater 20c. TIME OF INJURY Month, Day, Year Hour 3 21 19 67 p.m. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory 20f. (City or town) (County) (State) Childs Cecil Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 3/23/67	
EXAMINER'S NAME (Type) Charles S. Petty		23. DATE THEREOF 3/26/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. NAME OF CEMETERY OR CREMATORY Justice Cemetery	
23c. LOCATION (City or Town) (County) (State) Grundy, Virginia		23d. REC'D BY REGISTRAR MAR 29 1967	
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.		25a. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03193

03193

Jan. 13, 1934

U.S.A.

Virginia

W.R. Paper Co.

Laborer

George S. Sney

For Justice

200-18-1000 W.R. Paper Co., Justice, W.R.

to

County, Virginia

Justice Sney

200-18-1000

Justice

W.R. Paper Co., Justice, W.R.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03499

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03493

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>New Castle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u> 46-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>408 Harbour Drive</u>	
3. NAME OF DECEASED (Type or print) <u>David Mack Lilly</u>		4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. - Blasting Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Constr.</u>	9. AGE (In years last birthday) yrs. <u>78</u>
11. BIRTHPLACE (State or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bob Lilly</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA AKERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-16-7294</u>	
17. INFORMANT <u>Kenneth Lilly (son), Newark, Del.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John M. Byers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Mem. Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Beckley, West Virginia</u>
24. FUNERAL DIRECTOR <u>R.T. Jones</u>		25a. REC'D BY REGISTRAR <u>Newark, Delaware</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		MAR 17 1967	

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CERTIFICATE OF DEATH

03494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 9 Walnut St.	
3. NAME OF DECEASED (Type or print) HERMAN BOYER LOCKARD		4. DATE OF DEATH Month March Day 6 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1904
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. BIRTHPLACE (County & State, or foreign country) Cecil County Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Lockard		14. MOTHER'S MAIDEN NAME Emma Boyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-6566	
17. INFORMANT Mrs. Joanne L. Harrison		Address Walnut St. North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory failure DUE TO Pulmonary Infarction DUE TO Pulmonary Fibrosis 525X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 6, 1967 , to March 6, 1967 , that (I) (we) last saw the deceased alive on March 6, 1967 , and that death occurred at 7:55 A.M. from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera		22d. ADDRESS 105 E. Main St. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY North East Methodist	23d. LOCATION (City or Town) (County) (State) North East Cecil Md.
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR MAR 15 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jager			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G387 3/27/67 pc

03501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03495

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY Bellefontaine	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Box 206		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELBERT FAYE LOGAN		4. DATE OF DEATH Month March Day 10 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 28/12		9. AGE (In years lost birthday) yrs. 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Leesburg Ohio	
13. FATHER'S NAME Jester Logan		14. MOTHER'S MAIDEN NAME Emma Kerns		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Roberts Fun Home, Dayton Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Extreme Injuries. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 8120 (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by truck.			
20c. TIME OF INJURY Month, Day, Year Hour 8:00 p.m. 3/ 10 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
		20f. (City or town) (County) (State) Perryville Cecil Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 3/12/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Mar 13/67		23c. NAME OF CEMETERY OR CREMATORY East Leesburg Cem Ohio	
		23d. LOCATION (City or Town) (County) (State) Ohio			
24. FUNERAL DIRECTOR Philip Herwig Sons		ADDRESS 2024 Orleans Street 31		25a. REGISTRAR'S SIGNATURE Charles Judge	
		DATE MAR 15 1967			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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03502

CERTIFICATE OF DEATH

03496

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alver</u>		c. LENGTH OF STAY IN lb <u>19 Months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>		d. STREET ADDRESS <u>171</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nettie B. Lovejoy</u>		4. DATE OF DEATH <u>Mar 4, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1879</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u></u>		14. MOTHER'S MAIDEN NAME <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Albert Cooper</u>		Address <u>Charlestown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis, Hypertension, CVD</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1962</u> , to <u>March 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 22</u> 1967, and that death occurred at <u>7:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. H. Richards</u>		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/8/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rising Sun, Maryland</u>	
24. FUNERAL DIRECTOR <u>Lee C. Peterson & Son, Inc., Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>			

03100

STATEMENT OF DEBIT

03100

MAILED

MAR 10 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03503					03497				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
		ELDRIDGE	W.	LUSBY.			March	4,	1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1906		9. AGE (in years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer.			10b. KIND OF BUSINESS OR INDUSTRY Own Farm.		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME S. Wills Lusby.					14. MOTHER'S MAIDEN NAME Helen M. Schrack				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. (If yes give war or dates of service) 221-18-7197		17. INFORMANT Henry Syle,		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arteriosclerotic Heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable immediate cause of death was Ball-Valve thrombus									INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 15 Jan, 1967, to 4 Mar, 1967, that (I) (we) last saw the deceased alive on Mar 19 67, and that death occurred at 6:30 from the causes and on the date stated above.									
22a. SIGNATURE Wallace Obenshain					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7 Mar 67		
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D.					22d. ADDRESS Cecilton, Md. 21913				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.			23b. DATE THEREOF Mar. 8, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery.		23d. LOCATION (City, town or county) (State) Earleville, Cecil Co; Md.		
24. FUNERAL DIRECTOR Edward Fellows,					ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
03504					CERTIFICATE OF DEATH					03498							
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 3 wks. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D. # 3 d. STREET ADDRESS (Fair Hill) e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Martha Middle R. Last Mackey					4. DATE OF DEATH Month March Day 6 Year 19 67												
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Madison Watson						14. MOTHER'S MAIDEN NAME Martha Elizabeth Lambert											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT John E. Mackey, Rising Sun, Md. Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitigated carcinoma 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 year.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1/27 , 19 67 , to 3/6 , 19 67 , that (I) (we) last saw the deceased alive on 3/6 , 19 67 , and that death occurred at 12:40 M. from the causes and on the date stated above.																	
22a. SIGNATURE Peter Stavrakis										22b. DATE SIGNED 3/8/67							
22c. PHYSICIAN'S NAME (Type) Peter Stavrakis										22d. ADDRESS Elkton Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery				23d. LOCATION (City, town or county) (State) Fair Hill, Md.							
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.										25a. REC'D BY REGISTRAR MAR 14 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

03198

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Union Hill, Pa.

Union Hill, Pa.

(Fair Hill)

Union Hill, Pa.

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March

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May 28, 1881

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Female White

Pennsylvania

Howardsville

March 1880

James Madison

John B. Mackay, Union Hill, Pa.

No

Union Hill, Pa.

Union Hill, Pa.

Union Hill, Pa.

Union Hill, Pa.

Union Hill, Pa.

03505

CERTIFICATE OF DEATH

03499

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Curtisville 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 176 Bessemer Avenue	
3. NAME OF DECEASED (Type or print) First Jean Middle R. Last NIETO		4. DATE OF DEATH Month March Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-29-23
9. AGE (In years lost birthday) yrs. 43		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (County & State, or foreign country) Madison, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Rodgers		14. MOTHER'S MAIDEN NAME Sarah Seabury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 168-28-68-62	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 3 13 67 , 19 3 28 67 , 19 3 28 67 , 19 3 28 67 , that (b) (we) last saw the deceased alive on 3 28 67 , and that death occurred at 7:40 p.m. M, from causes and on the date stated above.			
22a. SIGNATURE <i>S. Goldgraben</i>		22b. DATE SIGNED 3 29 67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF April 1, 1967	23c. NAME OF CEMETERY OR CREMATORY hokewood Cemetery	23d. LOCATION (City or Town) (County) (State) Dorseyville, Pa
24. FUNERAL DIRECTOR <i>W. C. Patterson</i> Patterson Funeral Home, Perryville, Md.		25a. REC'D BY REGISTRAR APR 5 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT

03506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03500

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 07-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 137 Collins Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANDERSON PAINE		4. DATE OF DEATH Month Day Year 3 6 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1916
9. AGE (In years last birthday) 50 ? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Paine		14. MOTHER'S MAIDEN NAME Ollie Rush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 419-18-1556	
17. INFORMANT Dorothy Mae Hutchinson-		Address 137 Collins St Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholic intoxication DUE TO (b) 3220 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Purulent bronchitis and pulmonary emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz M.D.		22. DATE SIGNED 3-6-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 3/13/67		23c. NAME OF CEMETERY OR CREMATORY Providence Cem.	
23d. LOCATION (City or Town) (County) (State) Elkton, Maryland		25a. REC'D BY REGISTRAR MAR 15 1967	
24. FUNERAL DIRECTOR Coluk R. Bell		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03507

CERTIFICATE OF DEATH

03501

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 9 mos 18 days		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 3196 18th St., N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK ARTHUR PILGRIM		4. DATE OF DEATH Month Day Year March 16, 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-74
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months Days Hours Min. 92	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy man retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes S A W		16. SOCIAL SECURITY NO. 578-20-1620	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Terminal Broncho- Pneumonia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 1, 1966 , to March 16, 1967 , and that death occurred at 11:50 pm from causes and on the date stated above.			
22a. SIGNATURE Stephen A. Hegedus		22b. DATE SIGNED 3-17-67	
22c. PHYSICIAN'S NAME (Type) S. A. Hegedus, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/22/67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA
24. FUNERAL DIRECTOR Colin T. Rhinco		25a. REC'D BY REGISTRAR 301-124116 WASH DC	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03508

CERTIFICATE OF DEATH

03502

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Maryland		e. STREET ADDRESS 2917 E. Baltimore	
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE P. RAKOWSKI		4. DATE OF DEATH Month Day Year MARCH 26 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-01
9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Retired		12. KIND OF BUSINESS OR INDUSTRY Salesman	
13. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		14. CITIZEN OF WHAT COUNTRY U.S.A.	
15. FATHER'S NAME Joseph Rakowski		16. MOTHER'S MAIDEN NAME Kunugunda Shultz	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		18. SOCIAL SECURITY NO. 212 07 87 38	
19. INFORMANT VA Hospital Records, Perry Point, Md.		20. ADDRESS	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia DUE TO (b) Hypertension cardio-vascular disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 3-2- , 19 67 , to 3-26-67 , 19 67 , that the deceased died on 3-26-67 , and that death occurred at 2:50 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Stephen A. Hegedus		22b. DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) STEPHEN A. HEGEDUS, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/29/1967	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR HENRY W. JENKIN & Co., Baltimore, Maryland		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

03508

STATE OF TEXAS

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IN SENATE

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR ENDING DECEMBER 31, 1907

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03509

CERTIFICATE OF DEATH

03503

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Elkton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredricktown d. STREET ADDRESS 67-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANE Middle REDMOND Last REDMOND		4. DATE OF DEATH Month March Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 25, 1881
9. AGE (In years last birthday) 85 yrs.		10. FUND 1 YEAR Months 11 Days 11 Hours 11 Min.	11. FUND 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Clarke.	
14. MOTHER'S MAIDEN NAME Elizabeth English		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 163-01-1805		17. INFORMANT Martin Redmond, Address Georgetown, Md. 21930	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) none		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 Mar , 19 67 , to 31 Mar , 19 67 , that (I) (we) last saw the deceased alive on 31 Mar , 19 67 , and that death occurred at 11:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 2 Apr 67	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		22d. ADDRESS Cecilton, Md. 21913	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April, 3, 1967	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery.		23d. LOCATION (City, town or county) (State) Philadelphia, Pa.	
24. FUNERAL DIRECTOR Edward Fellows and Son.		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

03239

03203

1995, 2000, 2005, 2010, 2015, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060, 2065, 2070, 2075, 2080, 2085, 2090, 2095, 2100, 2105, 2110, 2115, 2120, 2125, 2130, 2135, 2140, 2145, 2150, 2155, 2160, 2165, 2170, 2175, 2180, 2185, 2190, 2195, 2200, 2205, 2210, 2215, 2220, 2225, 2230, 2235, 2240, 2245, 2250, 2255, 2260, 2265, 2270, 2275, 2280, 2285, 2290, 2295, 2300, 2305, 2310, 2315, 2320, 2325, 2330, 2335, 2340, 2345, 2350, 2355, 2360, 2365, 2370, 2375, 2380, 2385, 2390, 2395, 2400, 2405, 2410, 2415, 2420, 2425, 2430, 2435, 2440, 2445, 2450, 2455, 2460, 2465, 2470, 2475, 2480, 2485, 2490, 2495, 2500, 2505, 2510, 2515, 2520, 2525, 2530, 2535, 2540, 2545, 2550, 2555, 2560, 2565, 2570, 2575, 2580, 2585, 2590, 2595, 2600, 2605, 2610, 2615, 2620, 2625, 2630, 2635, 2640, 2645, 2650, 2655, 2660, 2665, 2670, 2675, 2680, 2685, 2690, 2695, 2700, 2705, 2710, 2715, 2720, 2725, 2730, 2735, 2740, 2745, 2750, 2755, 2760, 2765, 2770, 2775, 2780, 2785, 2790, 2795, 2800, 2805, 2810, 2815, 2820, 2825, 2830, 2835, 2840, 2845, 2850, 2855, 2860, 2865, 2870, 2875, 2880, 2885, 2890, 2895, 2900, 2905, 2910, 2915, 2920, 2925, 2930, 2935, 2940, 2945, 2950, 2955, 2960, 2965, 2970, 2975, 2980, 2985, 2990, 2995, 3000, 3005, 3010, 3015, 3020, 3025, 3030, 3035, 3040, 3045, 3050, 3055, 3060, 3065, 3070, 3075, 3080, 3085, 3090, 3095, 3100, 3105, 3110, 3115, 3120, 3125, 3130, 3135, 3140, 3145, 3150, 3155, 3160, 3165, 3170, 3175, 3180, 3185, 3190, 3195, 3200, 3205, 3210, 3215, 3220, 3225, 3230, 3235, 3240, 3245, 3250, 3255, 3260, 3265, 3270, 3275, 3280, 3285, 3290, 3295, 3300, 3305, 3310, 3315, 3320, 3325, 3330, 3335, 3340, 3345, 3350, 3355, 3360, 3365, 3370, 3375, 3380, 3385, 3390, 3395, 3400, 3405, 3410, 3415, 3420, 3425, 3430, 3435, 3440, 3445, 3450, 3455, 3460, 3465, 3470, 3475, 3480, 3485, 3490, 3495, 3500, 3505, 3510, 3515, 3520, 3525, 3530, 3535, 3540, 3545, 3550, 3555, 3560, 3565, 3570, 3575, 3580, 3585, 3590, 3595, 3600, 3605, 3610, 3615, 3620, 3625, 3630, 3635, 3640, 3645, 3650, 3655, 3660, 3665, 3670, 3675, 3680, 3685, 3690, 3695, 3700, 3705, 3710, 3715, 3720, 3725, 3730, 3735, 3740, 3745, 3750, 3755, 3760, 3765, 3770, 3775, 3780, 3785, 3790, 3795, 3800, 3805, 3810, 3815, 3820, 3825, 3830, 3835, 3840, 3845, 3850, 3855, 3860, 3865, 3870, 3875, 3880, 3885, 3890, 3895, 3900, 3905, 3910, 3915, 3920, 3925, 3930, 3935, 3940, 3945, 3950, 3955, 3960, 3965, 3970, 3975, 3980, 3985, 3990, 3995, 4000, 4005, 4010, 4015, 4020, 4025, 4030, 4035, 4040, 4045, 4050, 4055, 4060, 4065, 4070, 4075, 4080, 4085, 4090, 4095, 4100, 4105, 4110, 4115, 4120, 4125, 4130, 4135, 4140, 4145, 4150, 4155, 4160, 4165, 4170, 4175, 4180, 4185, 4190, 4195, 4200, 4205, 4210, 4215, 4220, 4225, 4230, 4235, 4240, 4245, 4250, 4255, 4260, 4265, 4270, 4275, 4280, 4285, 4290, 4295, 4300, 4305, 4310, 4315, 4320, 4325, 4330, 4335, 4340, 4345, 4350, 4355, 4360, 4365, 4370, 4375, 4380, 4385, 4390, 4395, 4400, 4405, 4410, 4415, 4420, 4425, 4430, 4435, 4440, 4445, 4450, 4455, 4460, 4465, 4470, 4475, 4480, 4485, 4490, 4495, 4500, 4505, 4510, 4515, 4520, 4525, 4530, 4535, 4540, 4545, 4550, 4555, 4560, 4565, 4570, 4575, 4580, 4585, 4590, 4595, 4600, 4605, 4610, 4615, 4620, 4625, 4630, 4635, 4640, 4645, 4650, 4655, 4660, 4665, 4670, 4675, 4680, 4685, 4690, 4695, 4700, 4705, 4710, 4715, 4720, 4725, 4730, 4735, 4740, 4745, 4750, 4755, 4760, 4765, 4770, 4775, 4780, 4785, 4790, 4795, 4800, 4805, 4810, 4815, 4820, 4825, 4830, 4835, 4840, 4845, 4850, 4855, 4860, 4865, 4870, 4875, 4880, 4885, 4890, 4895, 4900, 4905, 4910, 4915, 4920, 4925, 4930, 4935, 4940, 4945, 4950, 4955, 4960, 4965, 4970, 4975, 4980, 4985, 4990, 4995, 5000, 5005, 5010, 5015, 5020, 5025, 5030, 5035, 5040, 5045, 5050, 5055, 5060, 5065, 5070, 5075, 5080, 5085, 5090, 5095, 5100, 5105, 5110, 5115, 5120, 5125, 5130, 5135, 5140, 5145, 5150, 5155, 5160, 5165, 5170, 5175, 5180, 5185, 5190, 5195, 5200, 5205, 5210, 5215, 5220, 5225, 5230, 5235, 5240, 5245, 5250, 5255, 5260, 5265, 5270, 5275, 5280, 5285, 5290, 5295, 5300, 5305, 5310, 5315, 5320, 5325, 5330, 5335, 5340, 5345, 5350, 5355, 5360, 5365, 5370, 5375, 5380, 5385, 5390, 5395, 5400, 54

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03510

CERTIFICATE OF DEATH

03504

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Connecticut b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norwich		d. STREET ADDRESS 17 Braddway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET E. RYAN		4. DATE OF DEATH Month Day Year March 3 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-73
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Health	
11. BIRTHPLACE (County & State, or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Ryan		14. MOTHER'S MAIDEN NAME Mary Scott McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-54-9515	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Adeno-Carcinoma of Rectum with DUE TO (b) Metastasis to Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 154X			INTERVAL BETWEEN ONSET AND DEATH 5 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from Dec. 17, 19 65 , to March 3, 19 67 , and that death occurred at 1:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Edgar E. Folk III		22b. DATE SIGNED 3-5-67	
22c. PHYSICIAN'S NAME (Type) Edgar E. FOLK III M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF Mar. 6 1967	23c. NAME OF CEMETERY OR CREMATORY Swan Point	23d. LOCATION (City or Town) (County) (State) Providence, Rhode Island
24. FUNERAL DIRECTOR PETER J. BARRETT		25a. REC'D BY REGISTRAR MAR 9 1967	
ADDRESS 1328 Warwick Avenue Rhode Island		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03204

RECORD OF CASE

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Name		Address	
Age		Sex	
Date of Birth		Date of Admission	
Occupation		Referral Source	
Medical History		Physical Examination	
Laboratory Tests		Diagnosis	
Treatment		Prognosis	
Follow-up		Discharge	

03511

CERTIFICATE OF DEATH

03505

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland c. LENGTH OF STAY IN 1b 107 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS Rt 1, Box 170 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Louis Storath		4. DATE OF DEATH Month Day Year March 26 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899 September 20, /
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi-cab	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Junius Storath		14. MOTHER'S MAIDEN NAME Katherine Koos	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 219-07-8096	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Metastases to Thoracic Spine & Cachexia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/9/ , 19 66 , to 3/26 , 19 67 , and that death occurred at 1:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Stephen A. Hegedus		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) STEPHEN A. HEGEDUS, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Angela Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Harford, Maryland
24. FUNERAL DIRECTOR Cunningham & Son, Harford, Md.		25a. REC'D BY REGISTRAR MAR 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1280

0320

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03506

<p>1. PLACE OF DEATH</p> <p>e. COUNTY <u>CECIL</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CONOWINGO</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AT HOME</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CONOWINGO</u></p> <p>d. STREET ADDRESS <u>RURAL</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>GEORGE LOUIS TAYLOR</u></p>		<p>4. DATE OF DEATH <u>MARCH 26 1967</u></p>	
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>JAN. 18-1877</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>N.J.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>JOHN TAYLOR</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>FRANCES FLAHERTY</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>215-36-8378</u></p>	
<p>17. INFORMANT <u>ETHEL TYSON EDGEWOOD MD</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u></p> <p>4201</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DIED SITTING IN CHAIR</u></p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____</p>		<p>20f. (City or town) _____ (County) _____ (State) _____</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>. and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <u>Henry V. Davis</u></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u></p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>22b. DATE THEREOF <u>3-29-1967</u></p>	
<p>22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Col ora</u></p>		<p>22d. LOCATION (City, town, or county) <u>CECIL</u> (State) <u>MD</u></p>	
<p>23. FUNERAL DIRECTOR <u>Ermonett Mullen</u></p>		<p>24a. REC'D BY REGISTRAR <u>MAR 30 1967</u></p>	
<p>24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>		<p>DATE <u>MAR 30 1967</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03208

03213

Life

1955-56

1955-56

75

03208

13-37-1955-56

1955-56

CERTIFICATE OF DEATH

03507

03513

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> 07-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>32 N. Main Street</u>		d. STREET ADDRESS <u>32 N. Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Alvia</u> Middle <u>E.</u> Last <u>Todd</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin F. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Laurinda Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Walter Todd Sr., Port Deposit, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Hypertension Q.V.D.</u> DUE TO (c) <u>20 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-12</u> , 19 <u>67</u> , to <u>3-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-1</u> , 19 <u>67</u> , and that death occurred at <u>9P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Michael</u>		22b. DATE SIGNED <u>3/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr.</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-5-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Coloma, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 7 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03204

61380

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03508

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 149 E. High Street		e. STREET ADDRESS 149 E. High Street	
3. NAME OF DECEASED (Type of print) First ALMEDA Middle Walker Last WALKER		4. DATE OF DEATH Month March Day 16 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years last birthday) 50 48 yrs.
11. BIRTHPLACE (State or foreign country) TERRA HAUTE, IND.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NO INFO.		14. MOTHER'S MAIDEN NAME NO INFO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. HOME	
17. INFORMANT MATTHEW E. WALKER		Address NORTH EAST, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Arteriosclerotic Cardiovascular Disease. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 3/16/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-20-67	23c. NAME OF CEMETERY OR CREMATORY NORTH EAST METH.	23d. LOCATION (City or Town) (County) (State) NORTH EAST CECIL MD.
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME, ELKTON, MD.		25a. REC'D BY REGISTRAR DATE 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

03208

03216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03515

CERTIFICATE OF DEATH

03510

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sassafras. d. STREET ADDRESS 14-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle WHITTINGTON. Last 4. DATE OF DEATH Month March Day 3, Year 19 67		5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March, 20, 1891 9. AGE (In years last birthday) 75 yrs. 10. UNDER 1 YEAR Months 14 Days 2 11. UNDER 24 HRS. Hours 4 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home. 11. BIRTHPLACE (County & State, or foreign country) Queen's Anne's Co; Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIOMEN NAME Maria Hines.	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 222-05-6783 17. INFORMANT George Hines, Address Rural Millington, Md. 21651		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c) 4 hours INTERVAL BETWEEN ONSET AND DEATH 4 hours years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Near total blindness Ca of Uterus (treated) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1 Mar , 19 67 to 3 Mar , 19 67 , that (I) (we) last saw the deceased alive on 3 Mar , 19 67 , and that death occurred at 4 PM from the causes and on the date stated above.	
22a. SIGNATURE Wallace Obenshain M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5 Mar 67		22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D. 22d. ADDRESS Cecilton, Md. 21913	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March, 8, 1967 23c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery. 23d. LOCATION (City, town or county) (State) Sassafras, Kent Co; Md.		24. FUNERAL DIRECTOR Edward Fellows, ADDRESS Millington, Md. 21651 25a. REC'D BY REGISTRAR MAR 9 1967 25b. REGISTRAR'S SIGNATURE J Charles Judge	

03215

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2 0 4

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03516					03511				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil MARYLAND					a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton 07-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital					d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
JAMES CARROLL WOOLEYHAN			March 29, 1967						
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 12, 1889	77 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker			10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James A. Wooleyhan					14. MOTHER'S MAIDEN NAME Mary E. Stradley.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.			16. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Mrs. Isabel G. Wooleyhan, Cecilton, Md.		Address 21913		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Myocardial Infarction</i>									<i>Several days</i>
(c) <i>Myocardial Coronary Occlusion</i>									<i>Four days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Rolando Najera</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/30/67		
22c. PHYSICIAN'S NAME (Type) Rolando Najera, M.D.					22d. ADDRESS Union Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF April, 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery.		23d. LOCATION (City, town or county) (State) Chesapeake City, Md.		
24. FUNERAL DIRECTOR ADDRESS Edward Fellows and Son. Millington, Md.					25a. REC'D BY REGISTRAR APR 4 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

03516

03511

03511

Union Industrial

JAMES CARROLL WYNN

1911

James A. Coffey

1911

Union Industrial

1911

1911